A 10-Minute Guide to Health Reform

What's changing | Who does it affect | What you can do

Learn more at www.uhc.com/reform

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Health Care: A New Era

01 Health Care: a New Era
02 Step 1: Understand the Basics
06 Step 2: Discover the Facts Behind the Buzz
12 Step 3: Learn about Different Approaches to Health Reform
22 Terms to Know

Why did we put this booklet together?

UnitedHealthcare is committed to **helping people live healthier lives.**™ When it comes to health reform, our goal is simple: to help you understand what these changes mean for you.

We put this booklet together to give you the basic facts in an easy-to-read format.

Find more at
www.uhc.com/reform

When President Obama signed the **Affordable Care Act**, our country entered a new era of health care.

As the law of the land, health reform is changing how people get health care, how they get health insurance, what it costs and who pays for it. As a result, people are asking:

- What's changing, and what's staying the same?
- Should I get a different plan, or keep what I've got?
- If I need a plan, how do I get one?

Health reform and you

Health insurance is a valuable benefit for employees, especially because many employers help pay a part of its cost. If you already have a health insurance plan through work, in most cases it's still your best choice, even with health reform in place.

So, this is good news for people with insurance through their employer – not all that much is changing for you. But if you want to learn more about what's changing and coverage choices under health reform, or know someone who needs health insurance, then this 10-minute guide can help. It explains the main changes, and shows how people, in different situations, can make health reform work for them.

Sections in This Guide

1

Understand the Basics

How does health reform work, and how might it affect you?

Get started on the next page.

2

Discover the Facts Behind the Buzz

Everybody's talking about health reform. What are the facts behind the buzz?

3

Learn About Different Approaches

See how nine different people make health reform work for them. Which one is most like you – or someone you know?

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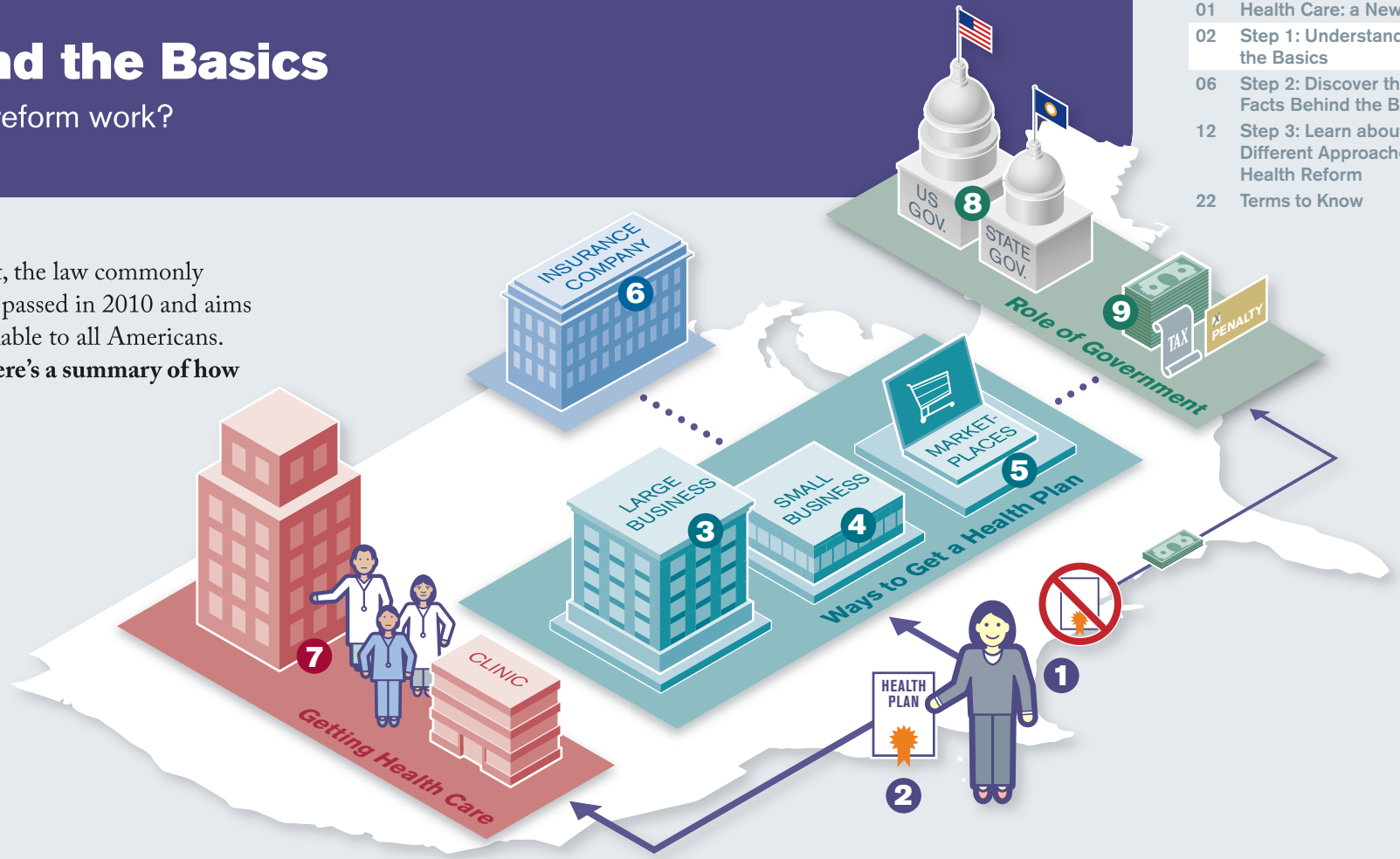
Understand the Basics

How does health reform work?

The Affordable Care Act, the law commonly known as health reform, passed in 2010 and aims to make health care available to all Americans. It's a complex law, but **here's a summary of how health reform works:**



❶ **Everyone** with few exceptions, is required to have health insurance. Health insurance is based on the idea of sharing costs across a large group of insured people.

People who choose not to buy health insurance must pay a penalty, or fee, each year. They must also pay for the costs of all their health care.

❷ **Most health insurance plans** include new benefits, like preventive care with no cost-sharing and coverage for pre-existing conditions.

WAYS TO GET A HEALTH INSURANCE PLAN

❸ **Large companies** (50 or more employees) typically offer health insurance plans to employees. Many also help pay for these plans. For people who work in large companies, getting insurance through their employer is often the easiest way to get a plan and likely the best option.

❹ **Small businesses** (fewer than 50 employees) can also provide health insurance to their employees – and some do this already.

People who work in small businesses may be able to get health insurance through their employer. Employers may work with the insurer either through the SHOP Marketplaces or outside the Marketplaces (like they do today). Employers can purchase insurance directly or through a broker, or with the help of Navigators in SHOP Health Insurance Marketplaces.

❺ **Health Insurance Marketplaces,** or "Exchanges," are a new way for people to shop for and buy a plan.

Marketplaces are meant to help people find a plan that meets the standards set by the federal government. While every state's Marketplace will offer plans from insurance companies, the Marketplaces themselves are set up and run either by the state, the federal government, or both together.

Each state's Marketplace will be divided between Individual (for families and individuals) and SHOP (health plans for small employers) Marketplaces.

❻ **Insurance companies** can sell plans through employers or directly to people—just as they have done in the past. Under health reform, they can also sell approved plans through the Marketplaces.

GETTING HEALTH CARE

❼ **Health care providers** are encouraged to provide efficient, quality care. Hospitals, doctors, and other providers may get paid more when they provide care that improves patient health, and less when they don't. To improve the delivery of health care and improve patient health, providers are finding ways to become more efficient by adding technology, streamlining processes, and coordinating care more effectively.

ROLE OF GOVERNMENT

❽ **Federal and state governments** run the Marketplaces. They also support specially trained people called "Navigators." Navigators provide helpful information to people and small businesses looking for health insurance.

❾ **Taxes and penalties** paid by employers help offset the costs of health reform. Insurance companies, drug makers, medical device makers, and others also pay taxes and fees to help offset the cost.

Understand the Basics

How could health reform affect you?

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Here are some of the most important changes that could affect you in 2014 and beyond. **These changes improve access to care, expand health insurance benefits, and may help lower costs.**

Improving Access to Health Care

You can choose your doctors, from among any primary care provider or pediatrician who's in your plan's network and accepting new patients.

You don't need approval in advance for emergency care, and emergency room visits count as in-network care. However, this applies only to real medical emergencies. People who use the emergency room when they don't need to may have to pay higher costs.

You don't need a referral for OB-GYN services – you can make an appointment directly with an obstetrical/gynecological doctor.

Most health insurance plans will cover certain preventive care services with no cost-sharing, including blood pressure and cholesterol screening, recommended immunizations and mammograms.

Expanding Health Plan Benefits

Health Insurance Marketplaces (also called "Exchanges") are a new way for people to buy health insurance. There are two types of Marketplaces – the Individual Marketplaces and the Small Business Marketplaces (SHOP). The Individual Marketplaces are where individuals and families can shop for a plan. The Small Business Marketplaces are where a small business can pick a plan or a range of plans from which its employees can choose. The plans offered in the Marketplaces must meet government requirements for coverage, quality and value.

You can't be denied coverage due to a condition like diabetes or heart disease. You can't be charged a higher premium because of your condition.

Most health insurance includes coverage for essential health benefits, such as doctor visits, hospital care and prescriptions. (This applies to both individual and small-employer plans.)

90 DAYS

If you are a new employee, the waiting period for health plan coverage to start can't be longer than 90 days.

Kids can stay longer on a parent's plan – until age 26.

26

Lowering Health Care Costs

Generally, your yearly insurance deductible is limited to $2,000 for individuals or $4,000 for families. (This applies to individual and small-employer plans.)

Yearly out-of-pocket costs for members of high-deductible plans are limited to $6,350 for an individual and $12,700 for a family in 2014. This includes co-payments, deductibles and co-insurance costs. After that, the plan pays all covered expenses.

Generally, at least 80 or 85 percent of insurance premium dollars must be used to pay for health care and activities to improve health care quality.

There are no lifetime or annual limits on essential health benefits. Your plan must keep paying for covered expenses that are considered essential health benefits.

Important to know

Employers who have had a plan in place for several years may not have to make some of the changes required under the Affordable Care Act. This is called a "grandfathered" plan. **If you have a plan that was created on or before March 23, 2010, check with your employer to learn about how health reform changes may apply.**

Discover the Facts Behind the Buzz

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The health reform law is designed to help more people get health insurance, control health care costs, and improve how people get health care. The law is called the Affordable Care Act, but most people just call it health reform. Whatever you call it, these changes are creating a lot of buzz.

Here are some things you might have heard – and the facts behind them.

1 The individual mandate

THE BUZZ

Everybody has to buy health insurance, or pay a penalty.

THE FACTS

Yes, there is a new federal government penalty on people who don't have health insurance. The penalty is in place to urge people to have health insurance. The penalty will start out small and go up each year.

If you have health insurance through your employer, you won't have to pay the penalty. In fact, most types of health insurance will excuse you from the penalty, including plans from Medicare, Medicaid, CHIP, Veterans Affairs, the Indian Health Service, Tricare, or a plan you buy yourself. If you truly can't afford a plan, you may qualify for help from the government to pay for one (See Affordability section below).

Those who choose to pay the penalty rather than buy health insurance, however, will be left to pay for all their health care costs. Paying the penalty does not give anyone free health care or health insurance coverage.

2 Affordability

THE BUZZ

The government's going to make health insurance more affordable for everyone.

THE FACTS

If your employer offers a plan that meets government standards and your employer pays part of the cost for your plan, most likely that's the best choice for you.

But for many other people, health reform will make health insurance more affordable. The government is creating standards for what are considered to be essential health benefits and affordable plans, providing new ways to get such plans through Marketplaces, and even helping to pay for it in some cases. This can work in several ways.

Those who can't get a health insurance plan through their employer can buy a plan in the new state Marketplaces (see page 8.) Plans in the Marketplaces are offered by health insurance companies and meet the new government standards for what they cover and their value.

Small businesses have a new way to provide a plan for their employees: special SHOP Marketplaces just for small businesses. These Marketplaces offer several plans, from various

What's the penalty?

The penalty is either a yearly fee or a percentage of your household income, whichever is more. For people with a health plan for only part of the year, the penalty is adjusted based on the number of months they went without a plan. If someone went without a plan for only three months or less, it doesn't count against him or her. The penalty will be collected as part of federal income tax returns. If the penalty isn't paid, the IRS will hold back the amount of the penalty from any future tax refunds.

To learn more about penalties, visit **www.healthcare.gov/glossary/fee.**

Want a quick refresher on some of these terms? Check the helpful **Terms to Know** section beginning on page 22.

Discover the Facts Behind the Buzz

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health insurance companies, that meet the new government standards, and tax credits are available for small businesses that qualify.

Those with a moderate or low income (less than $45,960 for individuals*) may also be eligible for financial assistance from the government to help pay for their plan, if purchased through Individual Marketplaces. Government subsidies pay for a portion of the cost you pay each month for a plan (the premium). Subsidies can be taken as a credit against annual federal taxes, or as a credit against the monthly plan premium.

People with low incomes can also get subsidies to help with out-of-pocket costs, like co-payments or co-insurance.

* The amount of financial help you can get depends on your family size and how much money your household earns. This figure is based on 2013 numbers and is likely to be slightly higher in 2014.

3 Health Insurance Marketplaces

THE BUZZ

The government is setting up markets to sell health plans.

THE FACTS

The government is not going to sell health insurance – but it is setting up new Health Insurance Marketplaces (also called "Exchanges" or "Marketplaces") in each state where health insurance companies can sell their plans. There are also special Marketplaces where small businesses can buy plans for their employees. Some Marketplaces will be run by a state, some by the Federal government, and some by both working together.

If your employer offers health insurance and contributes to the cost of coverage, that is likely to be your best choice. But people who aren't eligible for an employer-sponsored plan, or have an employer plan that is not considered "affordable" for them under the new government standards may benefit from the Individual Marketplaces.

The Individual and SHOP Marketplaces will offer a choice of plans providing different amounts of coverage at different prices. Marketplaces will also help buyers compare and understand the plan benefits. Some of the plans sold in the Marketplaces probably come from insurance companies whose names you know. There are different levels of plans to choose from (Bronze, Silver, Gold and Platinum). These plans generally provide coverage similar to plans being offered to individuals or offered through an employer today.

The Marketplaces have a set time period when you can compare and select a plan, called an open enrollment period. For most states, initial open enrollment begins October 1, 2013, and will run until March 31, 2014, for coverage effective January 1, 2014. After any open enrollment period ends, you will not be able to buy a plan through the Marketplaces (unless you have a qualifying life event) until the next annual open enrollment period.

Can you get a subsidy to help you buy a plan on your state's Marketplace?

The federal government determines your eligibility for a subsidy. However, the Kaiser Family Foundation offers a calculator that may give you a general idea of what the government may determine to be your eligible subsidy.

Find it at **www.kff.org/interactive/subsidy-calculator**.

To find out about your own state's Marketplace, visit **www.healthcare.gov**.

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People can shop and apply for a plan through the Marketplaces three ways: online, by mail, or in person with trained helpers called "Navigators." You can also get the help of insurance brokers or agents in all three methods of shopping.

4 Expanded Coverage

THE BUZZ

Under health reform, health insurance plans will provide better coverage than before depending on what the government considers to be essential health benefits in your state.

THE FACTS

It's true that some health plans will offer more coverage than before. To meet new standards set by health reform, plans must include certain preventive care services with no cost-sharing. This includes coverage for services such as health screenings and immunizations, and special preventive care for women including pre-natal office visits, breast-feeding supplies, and mammograms, which may or not have been included before.

Plans sold through the Marketplaces have to be qualified plans offering 10 kinds of benefits, called "essential health benefits." These include doctor visits and hospital care, prescription drugs, lab tests, maternity care and more. Plans sold outside the Marketplaces may also have these benefits.

5 Pre-existing Conditions

THE BUZZ

Health insurance companies must provide people with coverage even if they've had health problems in the past.

THE FACTS

It's true – under health reform, you can get health insurance even if you already have health conditions (often called "pre-existing conditions"). This is also true for dependents covered under your plan. And, you won't be charged more because of any pre-existing health conditions. The amount you pay each month is the same for people with and without pre-existing conditions.

While health reform helps people with serious health conditions get insurance, it's important to provide care that helps people maintain their health and keep any conditions under control. This approach can help avoid more health care costs in the long run. Health reform's focus on preventive care may also help people avoid developing some serious health conditions.

A new reason to quit

If you smoke or use tobacco, there's bad news. Your health insurance can now charge you up to 50 percent more. There's never been a better time to quit, so check with your employer or your current plan to see if there are programs or incentives to help you quit.

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These nine people want to make health reform work for them. **See how they're doing it.**

I **have** insurance

My employer offers health insurance, but…**I want to know my other options.**
—Chris, p14

My employer is offering me health insurance. **How can I get coverage for the rest of my family?**
—Sol, p14

I like the plan I have through my employer. **Is my plan going to change?**
—Jordan, p15

I **need** insurance

I work part-time and I'm not eligible for my employer's health insurance plan. What can I do?
—Desi, p16

I can't afford my employer's health insurance. **How can I get a plan I can afford?**
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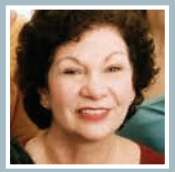
I'm new to this whole thing! **I don't have any health insurance. Where do I start?**
—Kendi, p16

I'm **in transition**

I'm going to be too old for my parents' health insurance soon. How can I get a plan I can afford?
—Jin, p18



I'm going to be 65 soon. **What are my Medicare options?**
—Pat, p18

I have a health condition that's kept me from getting health insurance. Can I get it now?
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Here's how these nine people are making health reform work for them.

Could one of these approaches work for you – or someone you know? To help put these ideas into action, see the How-Tos starting on **page 20**.

I **HAVE** INSURANCE

My employer offers health insurance, but… **I want to know my other options.**

An approach for Chris

Health reform does offer a new way to get health insurance: your state's Marketplaces. If your employer's plan meets government standards and is affordable (see Affordability, page 6), it is likely you won't qualify for government financial assistance – meaning Individual Marketplaces probably won't help you save money on a plan.

My employer is offering me health insurance. **How can I get coverage for the rest of my family?**

An approach for Sol

If your employer does not offer coverage for spouses or children, your spouse and children can buy coverage separately, directly from an insurance company or agent, or in the Individual Marketplaces.

Health reform does provide potential government financial help for people to pay toward the premium for a plan purchased in the Individual Marketplaces. Subsidies are based on household income and family size, so you'll want to complete an application for the Individual Marketplace, to determine whether or not you and your family qualify for financial help.

I like the plan I have through my employer. **Is my plan going to change?**

An approach for Jordan

In most cases, the best choice is to continue getting coverage through your employer. Many employers pay part of the cost for the plan, and this can be a big help to you.

Under health reform, you can expect your old plan to offer new protections. For example, your plan can't limit the amount it will pay per year or over your lifetime for essential health benefits. And you can't be denied coverage or charged more because of a pre-existing condition.

To help control rising health costs, many employers are choosing high-deductible plans. These plans require you to pay a deductible amount of several thousand dollars (for non-preventive care services) before the plan starts to pay for your health care. To help you pay for health expenses until you meet the deductible, many employers are adding health savings accounts, or HSAs, which let you pay for health expenses with pre-tax dollars. For many people, that's like getting a discount on their health care expenses.

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I **NEED** INSURANCE

I work part-time and I'm not eligible for my employer's health insurance plan. What can I do?

An approach for Desi

If your employer doesn't offer you coverage or their coverage doesn't meet the new government standards, you can buy a plan in your state's Individual Marketplace. You can also buy insurance from a health insurance company directly or through an insurance agent outside of the Marketplaces.

I can't afford my employer's health insurance. **How can I get a plan I can afford?**

An approach for Kelly

Health reform includes some incentives for employers to offer affordable plans to their employees. First, check with your employer to see if they are offering new, more affordable plans. If so, their plan is likely to be your best choice.

If your employer doesn't offer a plan that is affordable, use an online subsidy calculator to see if you can get help paying for a plan through the Individual Marketplace in your state. But only the Marketplace can determine if you will be eligible for government financial assistance. If you have a low income you may be able to get a government subsidy to buy a plan in the Individual Marketplaces. You'll have a range of plans to choose from.

I'm new to this whole thing! **I don't have any health insurance. Where do I start?**

An approach for Kendi

If you work at a small company, health reform is making it easier for your employer to offer a plan that meets the new government standards. Talk with the person in your company who handles benefits to learn what's available.

If you're not working, or your employer doesn't offer an affordable plan, you may be able to get a subsidy to help you buy a plan through the Individual Marketplace in your state.

What if I work for a small business?

Under health reform, small businesses have access to small business Marketplaces (SHOP) where they can make insurance coverage available for their employees and may be eligible for tax credits.

As a result, more small businesses may be able to offer health coverage for their employees. At first, employers may make only one plan in the SHOP Marketplaces available to their employees. But for 2015 (and in some states now), employers will be able to provide their employees with a choice of plans available through the SHOP Marketplaces. Talk with the person in your company who handles benefits to learn if a new plan is available to you.

If your employer doesn't offer a plan, or the plan does not meet the new government standards, you can buy one directly from an insurance company or agent, or through the Individual Marketplace in your state.

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I'M **IN TRANSITION**

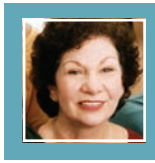
I'm going to be too old for my parents' health insurance plan soon. How can I get a plan I can afford?

If you're like Jin, you're going to be too old for your parents' plan soon, and you'll need to get your own plan.

An approach for Jin

First, make sure you're too old. Under health reform, you can stay on your parent's plan until age 26, even if you have graduated from college.

If you are getting close to age 26, and you don't have a job that offers health insurance, you can buy a plan through the Individual Marketplace in your state.



I'm going to be 65 soon. What are my Medicare options?

An approach for Pat

As you retire, you'll probably transition to Medicare coverage to pay basic health care costs, just as you would have done before health reform. You'll be enrolled in Medicare Part A automatically. But you must enroll in Part B during the open enrollment period, which starts three months before you turn 65 and lasts for seven months. Consider adding coverage to help with the costs Medicare doesn't pay. For example, a Medicare Supplement (Medigap) plan, a Medicare Advantage plan, or your employer's retiree health insurance plan. If your plan doesn't cover drugs, you may also want Part D prescription coverage.

If you're working past age 65, the rules are different. If your company has 20 employees or more, you can generally stay on your employer's plan. But be sure to enroll in Part B within eight months after you retire, or you may have to pay a penalty. If you work for a company with fewer than 20 employees, your employer's plan will provide only supplemental coverage after you're eligible for Medicare, so it's important to enroll in Part B as you near age 65.

I have a health condition that's kept me from getting health insurance. Can I get it now?

An approach for Akia

If you don't have health insurance because you couldn't get coverage or were charged extra because of a health condition, there's good news. Health reform means you can get the same plan as someone else without a health condition. Your application can't be denied because of your condition, and you can't be charged more because of it. And if you develop a serious condition while you have a plan, your coverage can't be cancelled because of the condition.

This applies whether you get your health insurance through your employer (within or outside of the SHOP Marketplace), through the Individual Marketplace, or directly from a health insurance company.

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How-Tos

The following How-Tos can help you put these ideas into action.

Find out if you can get help to buy insurance

If you can get health insurance from your employer, that's often your best choice.

You may be eligible for government financial assistance so you can buy a plan in your state's Individual Marketplace if:

- Your income is less than $45,960 as an individual or $94,200 for a family of four.*

AND

- Your employer's plan fails to meet the minimum value standard. This means it pays, on average, less than 60 percent of the overall cost of providing essential health benefits to plan members. If the plan falls below the level of 60 percent, its value is below the lowest level of plans, called Bronze plans, offered in state Marketplaces. The person in your company who handles benefits can tell you if your plan meets the Bronze level. If not, it fails this standard.

OR

- Your employer's plan fails to meet the government's affordability standard. It fails if the amount you pay toward your employer's plan for employee-only coverage is more than 9.5 percent of your yearly household income.

Find out what help you could get

If you're eligible for a government subsidy to help you buy a plan in your state's Individual Marketplace, you're probably wondering how much you could get. The answer depends on a few things. Fortunately, you can use an online subsidy calculator to do the math. The Kaiser Family Foundation offers a calculator. Find it at: **www.kff.org/interactive/subsidy-calculator**.

To use the calculator, you'll need to know if your employer's plan fails the standard for either value or affordability. But only the Marketplaces can tell if you are eligible for a government subsidy, after you complete an application for coverage through your state's Individual Marketplace.

Shop for a health plan in the Health Insurance Marketplace (Exchange)

In most states starting in October 2013, you can shop for plans on the website of your state's Marketplace. You can also shop by mail, phone, or in person with trained helpers called Navigators – or with insurance brokers or agents. These plans begin in January 2014. You can:

- choose from a range of plans at different costs and levels of coverage.
- compare plans side by side and use an online calculator to find out what each one will cost.
- find out if you qualify for government financial assistance from your state's Individual Marketplace to help pay your premium or out-of-pocket costs.
- enroll in a plan right on the website.

To find out about your own state's health insurance marketplace, visit **www.healthcare.gov.**

Learn more about your options under Medicare

If you're looking toward entering Medicare, there's a lot to learn and a lot of choices for supplemental coverage. UnitedHealthcare has created resources to help you explore choices, using easy-to-follow videos, illustrations, and descriptions. Learn more at **www.MedicareMadeClear.com.**

* The amount of help you can get depends on your family size and how much money your family earns. These figures are based on 2013 numbers and are likely to be slightly higher in 2014.

Terms to Know

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Here are simple definitions for some of the complex terms used to talk about health reform and health insurance.

You can find more terms at **www.justplainclear.com.**

Benefits

The health care items or services covered under a health insurance plan. Covered benefits and services not covered are defined in coverage documents for the health insurance plan. In Medicaid or CHIP, covered benefits and services not covered are defined in state program rules.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20 percent would be $20. The health insurance company or plan pays the rest of the allowed amount.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Sharing

The share of costs covered by your health insurance plan that you pay out of your own pocket. This term generally includes deductibles, co-insurance and co-payments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of services not covered.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000 per year, your plan won't pay anything until you've met your $1,000 deductible for covered health services subject to the deductible for that year. The deductible may not be applied to some services, such as preventive services.

Dependent Coverage

Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Essential Health Benefits

Benefits that individual and small group health plans must offer under the Affordable Care Act. They include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care.

Grandfathered Plan

An individual health insurance policy that is exempt from many changes required under the Affordable Care Act because it was purchased on or before March 23, 2010. Plans may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers.

Health Insurance Marketplace

A new transparent and competitive insurance marketplace where individuals and small businesses can buy qualified health insurance plans. Marketplaces offer you a choice of plans that meet certain benefits and cost standards.

Health Savings Account (HSA)

A bank account that lets people put money aside, pre-tax, to save and pay for health care expenses. The IRS limits who can open and put money into an HSA.

Individual Mandate

Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay a penalty. You won't have to pay a penalty if you have very low income and coverage is unaffordable for you, or if you have other reasons, including your religious beliefs. You can apply for a waiver asking not to pay a penalty if you don't qualify for the waiver automatically.

Terms to Know

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Medical Loss Ratio

A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80 percent. If a company's medical loss ratio is too low, it must refund some premium dollars to members.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Preventive Care Services

Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Qualifying Life Event

An event defined by the Internal Revenue Service that allows an individual to change their benefit selections. Examples of events may include marriage, birth of a child or death of a dependent.

Subsidy

A fixed amount of money or a designated percentage of the premium cost provided to help purchase health insurance.

Waiting Period

The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under an employer's health insurance plan.

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The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the back of the ID card.

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